Provider Tax Implementation

As stated above, the language in the State plan amendment detailing the provider assessment is not appropriate for inclusion in the reimbursement section of the State plan (4.19-A). To consider this plan for approval, CMS asks that you delete all references and details of the assessment in the submitted SPA version. However, apart from the reimbursement methodology, we will need to review the details of the provider assessment to ensure compliance with all applicable federal statutory and regulatory requirements. The following questions are intended to solicit additional information regarding the assessment.

Note: CMS deems the "assessment" a provider tax and will henceforth refer to the "assessment" in this RAI as such.

Response

The Department has removed references to the local government assessment from the SPA. A revised State Plan Amendment is attached.

1. The amendment proposes a tax that will be assessed on all privately owned providers of inpatient hospital services within the territorial boundary of a local government. A tax exclusive to privately owned providers of inpatient hospital services within a territorial boundary of a local government does not meet the broad-based requirements established under 42 CFR 433.68(c)(2). This regulation establishes that "if a health care-related tax is imposed by a unit of local government, the tax must extend to all items or services or providers (or to all providers in a class) in the area over which the unit of government has jurisdiction."

   Given the legislative restriction on private providers, the State may request a waiver from CMS of the broad based requirement, pursuant to 42 CFR 433.72(b), to exclude state-owned and non state-owned governmental providers from the tax proposed in this amendment. These waiver requests must be specific to each unit of local government in the State and must include information on the specific tax structure imposed by each unit of government. Please be advised that the earliest date a waiver can be effective is on the first day in the calendar quarter in which the waiver is received by CMS.

   The proposed amendment states that a waiver to exclude from the tax all state-owned government hospitals and non-state owned governmental hospitals that reside within a territorial boundary of a local government has been approved by CMS. CMS has not granted Colorado a waiver of the broad-based requirements established under 42 CFR 433.68(c)(2) for the purposes of this amendment. Nor, to our knowledge, has the State requested such a waiver of these provisions. Please provide documentation of the formal correspondence between CMS and the State of Colorado granting the waiver.

Response

The Department believes that a misstatement was made in the original SPA language and this caused the confusion. Instead of reading ". . . a waiver to exclude those providers from the assessment has been approved by CMS . . ." the SPA should have read, ". . . a waiver to exclude those providers from the assessment must be approved by CMS. . ."

No approval of any waiver concerning this SPA has been received by the Department, nor has the Department submitted any such waiver. The language in the original SPA was meant to demonstrate that a waiver must be approved by CMS prior to implementing the payment when a private-owned provider and a state-owned provider and/or non state-owned governmental provider exist within the territorial boundary of the unit of local government. That said, since the SPA may not address waivers or the assessment, this language has been removed from the SPA.

Colorado statute defines qualified providers for this proposed payment as "nongovernmental" licensed hospitals. The Department will submit a waiver from the broad-based requirements of the provider tax established under 42 CFR 433.72(b) to exclude state-owned government hospitals and non state-owned government hospitals that reside within the territorial boundary of a unit of local government from the assessment proposed in this amendment, when appropriate.

The Department will submit a separate waiver for each unit of local government where a private-owned hospital and a state-owned and/or non state-owned governmental hospital(s) reside within the territorial boundary of the unit of local government. In the event that a waiver is granted by CMS, where applicable, the Department will use the same general format for each waiver request thereafter.

For the first participant in this Program, Platte Valley Medical Center, which is located in the City of Brighton, Colorado, no waiver will be necessary, as that provider is the sole provider of Inpatient Hospital Services within the unit of local government and is covered under this State Plan Amendment.

Since the first provider in this Program is the sole provider of Inpatient Hospital Services within the participating unit of local government, the Department is also providing information related to the City of Brighton's governing structure, its jurisdictional authority over this provider, the by-laws of Platte Valley Medical Center, and documentation to verify that Platte Valley Medical Center is, indeed, the sole provider of Inpatient Hospital Services within the city limits.

The following items are included in the accompanying packet for review by the Office of General Counsel:

- ***City of Brighton Home Rule Charter***

- ***Letter from City of Brighton's General Counsel explaining the city's taxing authority over the hospital***
- ***Printed map of the City of Brighton's city limits, with the location of Platte Valley Medical Center circled. To view and enlarge this map online go to http://www.brightonco.gov/egov/docs/1184277755_742492.pdf***
- ***Verification from the Colorado Department of Public Health and Environment's hospital licensing and certification listings that Platte Valley Medical Center is the only hospital within the City of Brighton. See http://www.hfemsd1.dphe.state.co.us/hfd2003/homebase.aspx?Ftype=hospital&Do=list***
- ***A map of all hospitals in Colorado does not exist. However, the Colorado Hospital Authority has provided a listing of hospitals by city. See http://www.cha.com/index.php?option=com_content&task=view&id=45&Itemid=83***
- ***Proposed contract between the State and City of Brighton. As advised by the Department's Contracts and Purchasing Section, the State will enter into agreement via a contract, rather than a Memorandum of Understanding (MOU), as previously indicated.***
- ***By-Laws of Platte Valley Medical Center***
- ***For additional information on Platte Valley Medical Center refer to http://www.pvmc.org***

2. The amendment language detailing the provider tax does not establish that the tax meets the uniformity requirements under 42 CFR 433.68(d). Below, please address each of the following through the formal response to the RAI. (Again, CMS expects the language detailing the provider tax will be removed from the State plan amendment).

    a. The language does not demonstrate that the tax will be a uniform rate for all services (or providers of those items or services) in the class on all gross revenues or receipts, or on net operating revenues relating to the provision of all items or services in the State, unit, or jurisdiction.

Response

The assessment will be a uniform rate on all hospitals that provide inpatient hospital services within the jurisdiction of the unit of local government. Further, the assessment will not exceed 5.5% of net patient revenues for inpatient hospital services less Medicare and Medicaid revenues, as documented in the hospital's most recently audited Medicare/Medicaid Cost Report form 2552-96.

    b. The language does not establish the percentage of revenues that will be assessed by each local unit of government and for each class of service.

Response

Each participating local government will impose an assessment within their territorial boundary not to exceed 5.5% of net patient revenues for inpatient hospital services less Medicare and Medicaid revenues. The percentage assessed on inpatient hospital services may vary between units of local government, but the assessment will be uniform within each unit of local government and will not exceed 5.5% of net patient revenues for inpatient hospital services less Medicare and Medicaid revenues. The Department would like units of local government to have the flexibility to determine their assessment rate, based on their individual circumstances. All participating hospitals within the unit of local government's territorial boundary would be treated uniformly, but each unit of local government may implement the assessment at a different rate.

c. The language establishes that the tax will be a percentage of gross or net revenues of the provider, without specifying which revenue base will be used by each unit of local government and for each class of service.

Response

As directed by CMS, the Department will establish an assessment based on net patient revenues for inpatient hospital services less Medicare and Medicaid inpatient hospital revenues. These revenues will be documented in the most recently audited Medicare/Medicaid Cost Report form 2552-96.

d. The language establishes that the tax may exempt revenue from Medicaid and/or Medicare as determined by the local government. The exclusion of Medicaid and/or Medicare revenues must be applied uniformly to all providers within the class of services and within each unit of local government's local jurisdiction subject to the provider tax.

Response

All participating hospitals within the unit of local government's territorial boundary would be treated uniformly, but each unit of local government may implement the assessment differently. As directed by CMS, the assessment will be based on net patient revenues for inpatient hospital services less Medicare and Medicaid inpatient hospital revenues.

It is the Department's understanding of regulation 433.68(d) that either Medicare or Medicaid revenues, or both, may be excluded from net patient revenues for assessment purposes. The Department has chosen to exclude both for the following reasons: (1) The assessment base is lower, allowing more room under the UPL to maximize provider participation in the program; and (2) The purpose of the payment is to partially compensate Medicaid providers for unreimbursed costs associated with serving Medicaid clients. Excluding Medicaid revenues from the tax base eases the burden on providers who are serving a proportionately larger share of Medicaid clients. If it is not

permissible to exclude <u>both</u> Medicare and Medicaid revenues from the assessment base, the assessment will be revised to exclude only Medicaid revenues.

To aid in addressing the issues above, please provide a listing of each unit of local government that will impose the tax. For each unit of local government include the: imposed tax rate, the taxing base, the class of taxed service(s), a listing of all providers of inpatient hospital services within the unit of local government's jurisdiction, and whether each provider is subject to the tax. CMS will need to independently review each unit of local government and the exact taxing structure to be imposed by each unit of local government.

<u>Response</u>

Participants in the Local Government Inpatient Hospital Payment Program

Unit of Local Government	***City of Brighton, Colorado***
Imposed Assessment (Tax) Rate	***5.5%***
Assessment (Taxing) Base	***Net Patient Revenues Less Medicare and Medicaid Revenues***
Class of Assessment (Tax) Service	***Inpatient Hospital Services***
Providers in Local Jurisdiction	***Platte Valley Medical Center***
Providers Subject to Assessment (Tax)	***Platte Valley Medical Center***

At this time, only one unit of local government is participating in the assessment. Once the State Plan Amendment is approved, the City of Brighton, Colorado will impose the assessment. The only provider of inpatient hospital services within the city's jurisdiction is Platte Valley Medical Center, a private-owned hospital.

3. Within the SPA language, the State indicates that a local jurisdiction may "elect" to assess the tax. Prior to approving a permissible tax, CMS must be aware of all units of local government that will definitively impose the tax. Please explain the use of the term "elect" in the SPA language.

    a. Given that the term "elect" connotes an option to impose the provider tax, how will the State ensure that the provider tax is assessed within each local jurisdiction from year-to-year?

    <u>Response</u>

    It is not the Department's desire that the SPA would require all units of local government to participate in the assessment. Colorado's statute reads, "Subject to federal Medicaid rules and regulations, in any given year, a local government may elect to not assess the fee imposed on qualified providers." C.R.S. 29-28-103(1)(b)(II) (2006). It should be noted that many of the units of local government in the state do not have a hospital that provides inpatient hospital services. Further, in Colorado, many assessments (taxes) must be first approved by a vote of the citizens. It is not the Department's intent to suggest that the proposed assessment must or must not be approved by the voters of each unit of local government, as that determination lies with the unit of local government.

Additionally, it is not the Department's intent to mandate that each unit of local government participate in the assessment each year. A unit of local government may find that the assessment is burdensome and may discontinue its participation after participating in the previous year(s).

While the Department does not intend to submit a new SPA for reconsideration each year, the following language has been added as the closing sentence to the SPA. "Each October 1, the State shall submit to CMS a list of providers qualifying for the payment, the payment amounts, the participating local governments and, if necessary, demonstrate that hold harmless provisions have been met." Further, any local government that elects to participate will need to enter into a contract with the Department and follow the conditions of that contract and related regulations.

b. Please explain the "certification" process by the county.

Response

This language is used only in the State's enabling legislation from 2006 (Senate Bill 06-145) — not the SPA. Local governments will not be certifying local funds and this process is not related to the official "certification of public expenditures" (CPE) process as it is commonly understood. However, the Department will require units of local government to provide documentation to the Department that supports the amount of the assessment and the payment to participating hospital(s) that provide inpatient hospital services within the unit of local government. The Department does not believe this documentation is directly comparable to the CPE used to draw FFP for other payments made within the State Plan.

c. Please also detail the process through which the State will draw FFP and distribute these funds to qualified providers.

Response

The Department will promulgate regulations for the process that units of local government and their hospital(s) that provide inpatient hospital services must follow to receive the payment. The Department will enter into a contract between the State of Colorado and each participating unit of local government to ensure that assessments and payments are made in accordance with the State Plan. Each unit of local government and their hospital(s) that provide inpatient hospital services will provide proper, auditable documentation to the Department. The Department will record the amount of federal share paid to each participating unit of local government on the CMS-64.

Payments will be made to participating providers through their local government. (Senate Bill 06-145 does not allow the Department to make the final payment directly to

the provider.) This distribution will be made based on the reimbursement model in the State Plan. Simply stated, this methodology is largely based on the ratio of each individual participating hospital's unreimbursed Medicaid inpatient hospital costs divided by the summation of all unreimbursed Medicaid inpatient hospital costs for all participating hospital(s) within the unit of local government. The Department will have each unit of local government and participating hospital(s) that provide inpatient hospital services submit auditable information to confirm that the assessment occurred and that the final payment was received, as directed by the State, in accordance with the State Plan.

4. Please explain how the proposed tax structure and corresponding reimbursement methodology adheres to the hold harmless provisions under 42 CFR 433.68(f)(2) and (3). Based upon the language in the SPA, it appears that the supplemental payment is contingent upon collection of the provider tax. For each unit of local government, please demonstrate that there is no violation of the indirect hold harmless provisions at 433.68(f)(3)(i).

Response

While the initial participant in this program will be Platte Valley Medical Center, located in the City of Brighton, the Department's hope and intention is that the assessment and corresponding reimbursement methodology proposed in this SPA will apply not only to the City of Brighton and Platte Valley Medical Center, but to all units of local government and participating hospitals who join the program in the future—subject to CMS' current and future approval.

42 CFR 433.68(f)(2) specifies a taxpayer will be held harmless if "all or any portion of the Medicaid payment to the taxpayer varies based only on the amount of the total tax payment." Since the reimbursement is based on a hospital's Unreimbursed Inpatient Hospital Medicaid Costs, which are not directly related to the assessment base (a hospital's net inpatient hospital patient services revenues minus Medicare and Medicaid inpatient revenues), the methodology adheres to the hold harmless provision under 42 CFR 433.68(f)(2).

42 CFR 433.68(f)(3) states that a hold harmless provision will exist if "the state provides, directly or indirectly, for any payment, offset, or waiver that guarantees to hold taxpayers harmless for all or a portion of the tax." The sole payment returned to participating hospital(s) is the reimbursement amount based on Unreimbursed Inpatient Hospital Medicaid Costs. The State and units of local government will not offer any form of grant, tax credit, waiver, or any other vehicle to offset the assessment amount. Therefore, no hold harmless violation exists under 42 CFR 433.68(f)(3).

Reported Budget Impact

5. The State reports a budget impact of $0 on the CMS SF 179. Given the condition cited under question 3, above, that a State (and CMS) must be aware of the local government(s) that will definitively implement a provider tax prior to CMS approval, please revise the SF 179 to report a budget impact based on those local governments that will implement the tax used to fund supplemental payments under SPA 06-013.

Response

The CMS SF 179 has been updated to reflect the budget impact of the Local Government Payment to Platte Valley Medical Center in Brighton, Colorado. The table on the following page summarizes the derivation of this payment. Please note that this information covers SFY 07-08 as well as SFY 06-07 due to retroactivity.

Step	Estimated Assessment and Payment for Platte Valley Medical Center (Provider)	SFY 06-07	SFY 07-08
	Assessment Calculation		
1	Net Patient Revenues for Inpatient Hospital Services	**$28,230,572**	**$28,230,572**
2	Less Medicare and Medicaid Inpatient Revenues	**$12,373,764**	**$12,373,764**
3	Equals Uninflated Revenue Base (Step 1 minus Step 2)	**$15,856,808**	**$15,856,808**
4	Assessment Base (Step 3 Adjusted for Inflation) [1]	**$18,832,147**	**$19,584,744**
5	Assessment Rate	**5.5%**	**5.5%**
6	Provider Assessment (Step 4 multiplied by Step 5)	**$1,035,768**	**$1,077,161**
7	Total Provider Assessments for All Providers under the Local Government's Authority (only one provider)	**$1,035,768**	**$1,077,161**
8	Total Provider Assessments for All Participating Local Governments (currently only one local government)	**$1,035,768**	**$1,077,161**
9	Local Government's Assessment as a Percentage of All Participating Local Government's Assessments. (Currently only one local government.) (Step 7 divided by Step 8)	**100%**	**100%**
	Payment Calculation		
10	Federal Financial Participation Available under Inpatient Hospital UPL	**$59,934,353**	**$70,464,218**
11	Federal Financial Participation Available to Payment to All Providers under the Local Government's Authority. (Step 9 multiplied by Step 10)	**$59,934,353**	**$70,464,218**
12a	State Share of Payment to All Providers under the Local Government's Authority (Step 8)	**$1,035,768**	**$1,077,161**
12b	Federal Share of Payment to All Providers under the Local Government's Authority (minimum of Step 11 or Step 8.) Federal Share capped by Federal Financial Participation Available to Payment to All Providers under the Local Government's Authority.	**$1,035,768**	**$1,077,161**
12c	Total Amount Available for Payment to All Providers under the Local Government's Authority. (Step 12a plus Step 12b)	**$2,071,536**	**$2,154,322**
	Reimbursement Calculation		
13	Uncompensated Inpatient Hospital Costs	**$1,088,604**	**$1,088,604**
14	Inflated Uncompensated Inpatient Hospital Costs (Step 13 Adjusted for Inflation)[1]	**$1,292,867**	**$1,344,535**
15	Total Inflated Uncompensated Inpatient Hospital Costs for All Providers under Local Government's Authority (only one provider)	**$1,292,867**	**$1,344,535**
16	Percent of Provider Inflated Uncompensated Inpatient Hospital Costs Relative to Total Inflated Uncompensated Inpatient Hospital Costs under the Local Government's Authority. (only one provider) (Step 14 divided by Step 15)	**100%**	**100%**
17	Payment to Provider (Step 16 multiplied by Step 12c)	**$2,071,536**	**$2,154,322**
17a	State Share of Payment to Provider (Step 16 multiplied by Step 12a)	**$1,035,768**	**$1,077,161**
17b	Federal Share of Payment to Provider (Step 16 multiplied by Step 12b)	**$1,035,768**	**$1,077,161**

[1] Platte Valley Hospital's most recently audited cost reported was for year 2001. According to the Consumer Price Index ("CPI"), the U.S. city average inflation for Medical Care between years 2001 and 2006 (the most recent full year, used to determine SFY 07-08 calculations) was 23.51%. Similarly, the inflation for Medical Care between years 2001 and 2005 (used to determine calculations for the retroactive period, SFY 06-07 calculations) was 18.76%.

When another unit of local government chooses to participate in the Local Government Inpatient Hospital payment program, and the Department documents that they are qualified to participate, CMS will be notified through the Department. Please note the closing sentence of the SPA: "Each October 1, the State shall submit to CMS a list of providers qualifying for the payment, the payment amounts, the participating local governments and, if necessary, demonstrate that hold harmless provisions have been met."

Supplemental Payment Reimbursement Methodology:

6. The proposed supplemental payment reimburses for only inpatient hospital services. However, the language in the amendment includes the following Medicaid costs and Medicaid revenues used to calculate the supplemental payment: inpatient hospital services, outpatient hospital services, emergency hospital services, physician services, prescription drug services, dental services, transportation services, out stationing services and home health services. If the State intends to include all service costs and revenues listed above, please explain how the State justifies including costs and revenues beyond inpatient hospital services as a methodology for an inpatient hospital service supplemental payment.

Response

State statute requires the Department to include, at a minimum, all services referenced in this question as part of unreimbursed Medicaid costs for purposes of redistributing the provider assessments. However, through the direction of CMS, the Department shall limit consideration of unreimbursed Medicaid costs to only unreimbursed inpatient hospital services in the reimbursement methodology for the supplemental payment. This language is documented in the revised SPA submitted with this response.

7. The SPA indicates that all components of Medicaid costs and Medicaid revenues shall be distinctly identifiable on the provider's most recently audited Medicare/Medicaid cost report. Please provide the specific worksheets and lines references on the CMS-2552 that the State intends to use in the reimbursement calculation to determine all Medicaid costs and revenues listed in the reimbursement methodology. By service component, please specify the references used to determine Medicaid costs and revenues. If the State uses worksheets that report Medicare costs and revenues, how will the State use this information to derive Medicaid costs and revenues?

Response

The Department has included a guide below with line references and formulas to illustrate the reimbursement methodology. The following tables illustrate the derivation of costs and revenues for the assessment and reimbursement methodology.

Assessment Base (Relevant Inpatient Revenue)	
Relevant Inpatient Revenue = Gross Inpatient Revenue –Medicare Inpatient Revenue –Medicaid Inpatient Revenue	
Value	***Location in CMS 2552-96***
Gross Inpatient Revenue	Worksheet C, Part I, Column 6, Line 101
Medicare Inpatient Revenue	Worksheet D-4, Title XVIII, Column 2, Line 101
Medicaid Inpatient Revenue	Worksheet D-4, Title XIX, Column 2, Line 101 [2]

Reimbursement Base (Uncompensated Medicaid Inpatient Hospital Services)	
Unreimbursed Medicaid Inpatient Hospital Services = $\left(\frac{\text{Total Costs}}{\text{Total Charges}} \times \sum \text{Medicaid Inpatient Charges}\right) - \left(\frac{\text{Total Inpatient Charges}}{\text{Total Patient Charges}} \times \text{Total Medicaid Payment}\right)$	
Value	***Location in CMS 2552-96***
Total Costs	Worksheet C, Part I, Column 5, Line 101
Total Charges	Worksheet C, Part I, Column 8, Line 101
Medicaid Inpatient Charges	Title XIX, Worksheet D-4, Column 2, Line 101
Total Inpatient Charges	Worksheet C, Part I, Column 6, Line 101
Total Outpatient Charges	Worksheet C, Part I, Column 7, Line 101
Total Patient Charges	Total Inpatient Charges plus Total Outpatient Charges
Total Medicaid Payments	Title XIX, Worksheet E-3, Part III, Column 1, Line 57

8. The State intends to use Medicaid revenues as reported on the CMS-2552-96 as part of the calculation of the supplemental reimbursement methodology. Please explain why the State intends to use reported revenues from the cost report rather than actual paid claims to the provider of services from the MMIS.

Response

The Department proposes using the CMS-2552-96 for the following reasons:

- ***costs are audited,***
- ***information will be consistent since the same source can be used to gather cost, charges and revenues data,***
- ***costs are final (due to retroactivity, MMIS data is never "final").***

9. Please explain why the State intends to use the CPI for purposes of trending provider costs and revenues rather than the applicable CMS market basket.

[2] If Worksheet D-4 is unavailable for Title XIX, use the provider's grouping schedule to obtain Medicaid Inpatient Revenues.

Response

The Department believes that the CPI we have proposed is a better indicator of the health care market for the State. Also, use of this index is consistent with all other provider payment methodologies. However, if directed by CMS, the Department will change the inflation index to the applicable CMS market basket.

10. The SPA language establishes that "a local government shall determine which Medicaid cost and Medicaid revenue components are used to calculate the Local Government Inpatient Hospital payment within the territorial boundary of a local government." This language is subjective, and therefore, does not represent a comprehensive reimbursement methodology that fully describes the payment for which providers will receive. Please delete this language from the SPA. The State must provide specific criteria in the State plan that defines which Medicaid costs and revenue components will be used by each unit of local government to determine the reimbursement for the supplemental payment.

Response

The original language was intended to allow units of local government flexibility in the development of the payment. However, as directed by CMS, the Department has revised the SPA to eliminate this subjective language and will specify that each unit of local government must use the same distribution methodology. This language is documented in the revised SPA submitted with this response.

11. In addition, the SPA explains that "payments will be made consistent with the level of funds established and amended by the General Assembly, which are published in the Long Bill and subsequent amendments each year." The language also indicates that "rate letters will document any change in the total funds available." This language implies that reimbursement and/or payment amounts under SPA 06-013 are contingent upon funding of the State share as determined by the legislature. This language does not represent a comprehensive reimbursement method and must be removed from the State plan. If the State does not anticipate a source of State share for the payments under SPA 06-013 in future years, the State must amend SPA to end date the payments or delete the supplemental payment methodology in years where there is no available source of State share.

Response

The original language was developed with the assistance of CMS (the NIRT) several years ago. This language is consistent with language included with all other Supplemental Medicaid payment methodologies (including DSH payments) in the State Plan, Attachment 4.19-A. However, the revised SPA submitted with this RAI has deleted most of this language.

This payment is the last payment type available on a tiered payment system. The language in the SPA is intended to convey that message. We believe it is imperative that the following language be included in the SPA to protect providers.

"The Local Government Inpatient Hospital payment shall be made only if there is available federal financial participation under the Medicare Upper Payment Limit after the Medicaid reimbursement, the High Volume Payment and the Pediatric Major Teaching payment." (This language is located in the last sentence of the second paragraph in Section A of the SPA.)

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A of your State plan, including payments made outside of those being amended with this SPA. If you have already provided updated comprehensive responses to other requests for additional information and that methodology information has not changed, you may refer us to that response. Please indicate the SPA and date of the response.

12. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers retain all of the Medicaid payments including the Federal and State share (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).

    Response

    For the Local Government Inpatient Hospital payment the Federal and State share is retained by the provider and no portion of the payment is returned to the State, local governmental entity, or any other intermediary organization.

    For other payments made under 4.19-A, the Department provided a response to this question in the Request for Additional Information for Colorado State Plan Amendment (SPA) 05-015. Please refer to the Department's response dated March 14, 2006.

13. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the

total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

(i) a complete list of the names of entities transferring or certifying funds;
(ii) the operational nature of the entity (state, county, city, other);
(iii) the total amounts transferred or certified by each entity;
(iv) clarify whether the certifying or transferring entity has general taxing authority; and,
(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response

For the Local Government Inpatient Hospital payment, the State share is from provider assessments. The estimated total expenditure, for SFY 07-08 as well as the retroactive period (SFY 06-07) is $4,225,858 and the State share is $2,112,929.

For other payments made under 4.19-A, the Department provided a response to this question in the Request for Additional Information for Colorado State Plan Amendment (SPA) 05-015. Please refer to the Department's response dated March 14, 2006.

14. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Response

The FY 2007-08 estimated total computable for supplemental or enhanced payments is provided below:

Payment Type Covered in Attachment 4.19A	State Owned Government	Non-State Owned Government	Private	Total Expenditure
Low-Income Shortfall Payment (DSH Payment)	$0	$0	$618,668	$618,668
Bad Debt Payment (DSH Payment)	$0	$0	$0	$0
Low-Income Payment (DSH Payment)	$17,013,110	$69,656,467	$261,816	$87,550,061
High-Volume Payment (Supplemental Inpatient UPL Payment)	$19,485,362	$26,892,138	$25,301,078	$101,477,270
Pediatric Major Teaching Payment (Supplemental Inpatient UPL Payment)	$0	$0	$34,791,049	$34,791,049
Urban Safety Net Provider Supplement Medicaid Payment (Supplemental Inpatient UPL Payment)	$0	$5,400,000	$0	$5,400,000
Local Government Inpatient Hospital	$0	$0	$4,225,858	$0

Payment (Supplemental Inpatient UPL Payment)				

The Local Government Inpatient Hospital payment is a Supplemental Medicaid payment for Inpatient Hospital Services. The estimated total expenditure for SFY 07-08 along with the retroactive year (SFY 06-07) is $4,225,858 and the State share is $2,112,929. The payment is made to private-owned providers.

15. Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers in Attachment 4.19-A (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide detailed calculations of your reasonable UPL estimates for SFY 2006.

Response

Since the response submitted in question 14) is for SFY 2008, the Department will also provide the detailed calculations for our reasonable UPL estimates for SFY 2008 in Attachment A. These are the most recent calculations available to the Department.

The Medicare Inpatient Upper Payment Limit (Inpatient UPL) is the maximum Medicaid can reimburse providers and still receive federal financial participation for inpatient hospital services. The Inpatient UPL is a prospective stand-alone calculation for any state fiscal year and is based on a prospective reimbursement model. The Inpatient UPL must be a reasonable estimate of the potential provider reimbursement under Medicare Payment Principles under current conditions; it does not represent actual Medicaid reimbursement, actual Medicaid provider costs or actual Medicaid (or Medicare) reimbursement due to the provider. The calculation is done for three separate provider categories: state-owned government hospitals, non-state owned government hospitals and privately owned hospitals. Significant amendments to federal regulations for Maximum Allowable Medicare Inpatient UPL and changes to the Medicaid Reimbursement require the Department to recalculate the Inpatient UPL. The Department's Inpatient UPL methodology was approved by the Inpatient National Reimbursement Team on May 27, 2004.

The procedure for calculating the Inpatient UPL, based on Medicare Cost, is as follows:

Reasonable Estimate of Inpatient UPL = Medicaid Discharges * Medicaid Case Mix * Inflated Medicare Cost Per Discharge

Such that,

- ***Medicaid Discharges are the number of fee-for-service discharges covered under Colorado Medicaid. These figures will contain a lag to be inflated forward to the current year using the Medicaid caseload forecast as submitted with the November 1 Budget Request. In addition, the fee-for-service discharges will be modified to include changes in HMO enrollment.***

- ***Medicaid (fee-for-service inpatient) Case Mix from inpatient utilization review data is applied. These values will be reported with a lag, and will not be adjusted to estimate the current case mix.***
- ***Inflated Medicare Cost Per Discharge is the inflated Medicare Cost Per Discharge to adjust to the State Fiscal Year for which the UPL is calculated relative to the fiscal year end of the Medicare Audited Cost Report. The inflation factor is the Medicare Economic Index (MEI) for inpatient hospital reimbursement, converted into State Fiscal Years. The MEI effective as of October 1 of each fiscal year will be used as the inflation factor for the current year.***
- ***Medicare Cost Per Discharge = Adjusted Medicare Total Payment/Medicare Discharges***
- ***Adjusted Medicare Total Payment = Adjusted Medicare DRG Payment + Medicare Total Audited Inpatient Costs - Net Medicare DRG Payments.***
- ***Adjusted Medicare DRG Payment = Net Medicare DRG Payments * (Medicaid Case Mix/Medicare Case Mix) * Case Mix Difference. The ratio of Medicaid Case Mix/Medicare Case Mix is necessary to adjust for the case mix difference between Medicare and Medicaid at a specific hospital.***
- ***Net Medicare DRG Payments are the sum of all Other DRG Payments and Gross Outlier Payments.***
- ***Other DRG Payments are the values found on Worksheet E, Part A, Lines 1 through 1.02 (or E-3 Part I or II). The values will be retrieved from the most recently available audited Medicare Cost Report [CMS 2552-96] available March 1 prior to the fiscal year.***
- ***Gross Outlier Payments are the values found on Worksheet E, Part A, Lines 2 and 2.01. The values will be retrieved from the most recently available audited Medicare Cost Report [CMS 2552-96] available March 1 prior to the fiscal year.***
- ***Case Mix Difference is the general percentage that the Medicare Case Mix exceeds the Medicaid Case Mix. This is necessary to adjust for the general case mix difference between Medicare and Medicaid since rebasings are done in different periods and using different budget neutrality, or non-neutrality, conditions.***
- ***Medicare Total Audited Inpatient Costs equal the value found on Worksheet E, Part A, Line 16, which includes IME, GME, and DSH (or E-3 Part I, Line 4 and Line 13). The values will be retrieved from the most recently available audited Medicare Cost Report [CMS 2552-96] available March 1 prior to the fiscal year.***
- ***Medicare Discharges are the value found on Worksheet S-3, Part I, (Excludes Subprov.). The values will be retrieved from the most recently available audited Medicare Cost Report [CMS 2552-96] available March 1 prior to the fiscal year.***
- ***Estimated Medicaid FFS DRG Payments made under the Inpatient UPL will be estimated by Medicaid Discharges * Medicaid Case Mix * Medicaid Base Rate. The Medicaid Base Rate will be the base rate effective on July 1 of the prior State Fiscal Year.***

- ***For TEFRA hospitals and Critical Access Hospitals there is no adjustment for case mix or costs and there is no case mix multiplier when calculating the Inpatient UPL for the specific hospital (Inpatient UPL = Medicaid Discharges * Inflated Medicare Cost Per Discharge). TEFRA hospitals have Medicare costs that are pulled from Worksheet E-3, Part I, lines 4 (a subtotal made up of Inpatient Hospital Services plus Organ Acquisition plus Cost of Teaching Physicians from lines 1, 2, and 3) and line 13 (Direct Graduate Medical Education Payments). The values will be retrieved from the most recently available audited Medicare Cost Report [CMS 2552-96] available March 1 prior to the fiscal year.***

16. Does any public provider receive payments that in the aggregate under Attachment 4.19-A (normal per diem, DRG, DSH, supplemental, enhanced, other) exceeds their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

Response

The Local Government Inpatient Hospital payment is a Supplemental Medicaid payment to private-owed providers and is made within the current Inpatient Hospital UPL calculation.

For other payments made under 4.19-A, the Department provided a response to this question in the Request for Additional Information for Colorado State Plan Amendment (SPA) 05-015. Please refer to the Department's response dated March 14, 2006.